AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

October 11, 2012

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Guidance

10/4/12 HHS published a correction to the final rule, Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets. The final rule implements portions of §1104 of the ACA which requires the adoption of a standard national unique health plan identifier (HPID). The final rule was published in the Federal Register on September 5, 2012. HHS projects that the net savings of implementing HPID for the health care industry is between $1.3 billion and $6 billion over ten years.

The rule adopts the use of and establishes requirements for the implementation of HPID. Furthermore, the final rule implements another data element, other entity identifier (OEID), for entities that are not health plans, health care providers, or individuals but need to be identified in standard transactions. The rule also specifies when an organization must require certain non-covered individual health care providers who are prescribers to obtain and disclose a National Provider Identifier (NPI).

The final rule also finalizes a one-year proposed delay and changes the compliance date to October 1, 2014 for use of new diagnosis codes that classify diseases and health problems. These code sets, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include codes for new procedures and diagnoses that improve the quality of information available for quality improvement and payment purposes.

This regulation is the fourth in a series issued by HHS aimed at streamlining health care administrative transactions and maximizing the use of existing standards by providers. Read

more about the other regulations at: CMS

Read the correction at: http://www.gpo.gov/fdsys/pkg/FR-2012-10-04/pdf/2012-24329.pdf

10/3/12 CMS published a correction to an ACA-related Medicare final rule called "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers." The final rule implements portions of the following sections: 3001, 3005, 3008, 3011, 3014, 3021, 3025, 3106, 3123, 3124, 3125, 3137, 3141, 3401, 5503, 5506, 10302, 10309, 10312, 10313, 10314, 10319, 10322 and 10324.

The rule, which was published in the August 31, 2012 Federal Register, revises the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals. The changes are generally applicable to discharges occurring on or after October 1, 2012. The rule also updates the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The updated rate-of-increase limits will be effective for cost reporting periods beginning on or after October 1, 2012.

The rule updates the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). Generally, the changes will be applicable to discharges occurring on or after October 1, 2012. In addition, the rule implements changes relating to determining a hospital's full-time equivalent (FTE) resident cap for the purpose of graduate medical education (GME) and indirect medical education (IME) payments. The rule establishes new requirements or revised requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that are participating in Medicare. The rule also establishes requirements for the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program.

Read the correction at: http://www.gpo.gov/fdsys/pkg/FR-2012-10-03/pdf/2012-24307.pdf

Prior guidance can be viewed at www.healthcare.gov

News

10/4/12 HHS/Department of Justice (DOJ) announced that the Medicare Fraud Strike Force joint agencies' national health care fraud and prevention enforcement operations in seven cities has resulted in charges against 91 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $429 million in false billing. Dozens of the charged individuals were arrested or surrendered.

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes and money laundering. The charges are based on alleged fraud schemes involving various medical treatments and services such as home health care, mental health services, psychotherapy, physical and occupational therapy, durable medical equipment and ambulance services.

In addition to the charges against the 91 individuals, the administration used new authority from the ACA to suspend all future payments to 30 health care providers suspected of fraud

until an investigation is complete. Currently, the Obama administration is implementing enhanced provider screening and enrollment requirements, increased data sharing across government agencies, expanded overpayment recovery efforts and greater oversight of private insurance abuses as authorized by Title VI, Transparency and Program Integrity, of the ACA.

The joint DOJ and HHS Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators and prosecutors designed to combat Medicare fraud through the use of Medicare data analysis techniques. The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a joint initiative announced in May 2009 between DOJ and HHS to prevent and deter health care-related fraud.

Read the press release at: http://www.hhs.gov/news/press/2012pres/10/20121004a.html

To learn more about the joint HHS/DOJ efforts to prevent and deter Medicare fraud, visit: www.stopmedicarefraud.gov

9/28/12 CMS announced that two new Consumer Oriented and Operated Plan (CO-OP) repayable loans will be awarded to non-profit entities to help establish private non-profit, consumer-governed health insurance companies that offer qualified health plans in the health insurance exchanges. Established under §1322 of the ACA, the goal of the CO-OP program is to create a new CO-OP in every state in order to expand the number of exchange health plans with a focus on integrated care and plan accountability.

One non-profit receiving a loan is: **Louisiana Health Cooperative, Inc. (LAHC)**, a CO-OP that received a $65,040,660 loan to improve health outcomes by providing better access to high quality care at an affordable cost. LAHC is sponsored by a coalition of providers and business leaders. According to their proposal, LAHC plans to provide statewide coverage in Louisiana by promoting and supporting the delivery of integrated healthcare in each of their products and services. LAHC will participate in the individual and small group Health Insurance Exchanges operating in Louisiana, as well as in the health insurance marketplace outside of the Exchange.

Another non-profit receiving a loan is: **Evergreen Health Cooperative Inc.**, a CO-OP that received a $65,450,900 loan to provide high quality, affordable care to Maryland residents while creating innovative forms of healthcare delivery. Evergreen will offer health insurance plans statewide and in the Maryland Health Benefit Exchange.

Starting in 2014, CO-OPs will be able to offer plans both inside and outside of health insurance exchanges and will operate in 22 states, including: Louisiana, Maryland, Massachusetts, Tennessee, Colorado, Utah, Kentucky, Vermont, Arizona, Connecticut, Michigan, Nevada, Maine, South Carolina, Oregon, New Mexico, Montana, Iowa, Nebraska, Wisconsin, New Jersey, and New York. CMS awarded the first round of CO-OP loans on February 21, 2012. To date, a total of $1,691,348,280 has been awarded. CMS will continue to review applications on a quarterly schedule through December 31, 2012 and announce additional awardees on a rolling basis. According to CMS, CO-OP loans are only made to private, nonprofit entities that demonstrate a high probability of financial viability.

For more information, including a list of previous CO-OP loans awarded, visit: http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html

Upcoming Events

Money Follows the Person (MFP) Working Group Meeting
November 28, 2012, 2:00 PM -3:30 PM
State Transportation Building
10 Park Plaza
Boston, MA 02116

Please contact MFP@state.ma.us if you would like to attend the meetings.
Requests for reasonable accommodations should be sent to MFP@state.ma.us. Although an RSVP is not required, it is appreciated.

An **MFP 101 introductory session** will also be held at the State Transportation Building on November 28, 2012 from 1:30 PM-2:00 PM for those not familiar with MFP.

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.